Insurance Premium Payment Assistance
Client/Parent/Guardian
Reimbursement
Set-Up Form

Complete this form and attach a copy of your Social Security card showing your name and Social Security number.

Parent/Guardian's (or Adult Client's) Name: _____

Parent/Guardian's (or Adult Client's) Social Security #: _____

CIDC Client's Name: _____ CIDC Case #: _____
LAST FIRST MIDDLE

Mailing Address: _____ TX _____
STREET ADDRESS OR PO BOX CITY STATE ZIP CODE

Telephone Number: _____
(AREA CODE) NUMBER

Mail to:

TEXAS DEPARTMENT OF HEALTH
Chronically Ill & Disabled Children's (CIDC) Services Program
1100 West 49th Street Austin, Texas 78756

Phone #: 1-800-252-8023 x3058 **Client/Parent fax #: 1-800-441-5133**

PLEASE DO NOT WRITE BELOW THIS LINE:

State Employee? YES ☐ NO ☐

Ownership Code - 1 Individual Recipient (not owning business)

Provider Number: _____ _____
(COMPTROLLER NUMBER) (LOCAL NUMBER)

Effective Date: _____ Date Entered: _____

PE Processor: _____

ATTN: PROVIDER ENROLLMENT - PLEASE RETURN THIS TO THE CLIENT SUPPORT SERVICES SECTION